DISABILITY DETERMINATION SERVICES

Melissa Willey, Unit 9, Medicaid Supervisor

Ellen Panella, Unit 42, Medicaid Supervisor

Robin Whitaker, Unit 44, Medicaid Supervisor

Kristina Rock, Unit 45, Medicaid Supervisor

DISABILITY DETERMINATION SERVICES

We are the state agency that makes the medical determinations on claims for Social Security Disability, Supplemental Security Income (SSI), and Medical Assistance for the Disabled.

AGENCY STATISTICS

- 160,000 - 180,000 FEDERAL CLAIMS PROCESSED ANNUALLY

- 39,000 – 40,000 MEDICAID CLAIMS PROCESSED ANNUALLY

DDS is authorized 745 positions – 615 assigned

- Federal Hiring Freeze & High Attrition
- 55% of examiners – less than 36 months experience

AGENCY STATISTICS

- 27 Federal Units
  - working with 37 social security offices in NC
    (fully electronic environment)

- 4 Medicaid Units (state funded with 26 adjudicating staff)
  - working with 100 county offices in NC
    (paper environment - applications mailed)
  - Unable to print NCFAST Assessment

4037 REQUIREMENTS

This information should be correct and clearly written

- Complete name
- Complete address
- SSN
- Date of birth
- Gender
- Area code and phone numbers
- County Code
- NCFAST application number
- Application date
- Worker name and contact number
- Any special instructions or remarks (i.e., reopening, review, deceased)

5009/ASSESSMENT Requirements

Claimant identifiable information on each page

Complete all fields on application

- ✓ Person providing information if not claimant
- ✓ List all medical sources for the past 12 months (include address and telephone numbers, conditions treated and dates seen)
- ✓ Third Party contact
- ✓ All allegations and alleged onset
- ✓ Work history and VR information
- ✓ Education information
- ✓ County worker observations

11/7/16

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL HISTORY SUMMARY FOR THE DISABLED

[redacted] County Department of Social Services Date Nov-09-2016

Claimant [redacted] SSN ______

County Case # ______ District # ______

Telephone # or a number you can be reached ______

Person Providing Information and Telephone # (if different from claimant) ______

Nature of Disability (based on claimant's description or statement)

Fibromyalgia PTSD
migranes
paralyzed right side - drop foot
3 tier plate front of neck
raspie voice

35 years ago - ran of road and hit tree [illegible]
No ~~skin~~ most still - spinal cord w/ nine [illegible] [illegible] ([illegible])
disc damage
right arm and wrist rotator cuff
sciatica
loss of vision

I. Onset of Impairment

A. Date of illness or injury began June 7, 2014 (most recent from)

B. Date claimant stopped work 33 years ago - slip and fall - neck & lower back surgery.

C. Date the illness or injury became disabling 33 years ago

D. If still working:

Name of Employer ______

Supervisor's name and telephone # ______

Hours worked ______

Gross earnings ______ weekly ______ monthly ______

II. Claimant's Description of Impairment

A. Indicate how the claimant describes the symptoms of the disability and how they affect his ability to work.

Has to take pain medication. Can't sit or walk very long. Constant movement. Going to the bathroom is hard due to the surgeries and sciatica. Much that's in here than from car accident. Needs further surgery.
Pain everyday. Under Anesthsia Manipulation made her pain worse. Had a pump placed for pain releif. ~~had~~ But had to remove it. 3 neck surgries and 5 lower back. Constant pain.

DMA-5009 (08-08)

Page 1 of 2 of Medicaid application (DMA5009)

IV. List all Medical Sources (physicians, hospitals, emergency facilities, health departments, therapists, nursing homes, clinics, mental health centers,) including names and dates seen in the last twelve months. Give hospital or clinic number, which is on hospital or clinic card or hospital bills. (Twelve months prior to and including application month, plus any future medical appointments)

Medical Source Name, Address, Ph. #	Condition Treated EKG, X-rays	Dates Seen at Dr.'s office, clinic, hospital
Dr. Mackinzie Broward General Hosp, Fl. 1600 S Andrews Ave. Fort Lauderdale, Fl 33316	Neck & lower back	1990 954-355-4400
Holy Cross Hospital Ft. lauderdale, Fl	neck	
Dr. Greiskie 954-771-8000 4725 N Federal Hwy Ft. lauderdale Fl. 33308	Brain	
Dr. Pain mangement / Hospital Rehab Ft. lauderdale 4730 NW 15th Ave	N. Broward Hospital Ft. lauderdale, Fl. 33309	954-493-6859

Is claimant still being treated? Yes ✓ No ___

V. VR Referral _____ **Yes** _____ **No Date last seen** _____

VR Office _____

Counselor's Name _____ **Phone #** _____

VI. If a mental impairment is alleged, if there is evidence of drug or alcohol abuse or if the person is homeless, in a shelter or in a halfway house, please give name, address and phone number of someone who can be contacted as a third party.

Dr. Van Christopher Clause
North Shore, Fl
Private practice
9526 N.E 2nd Ave
Suite 101
Miami Shores, Fl 33138
305-604-3775

Memorial Regional 3501 Johnson St.
Hollywood, Fl. Hollywood, Fl. 3312
954-987-2000
954-987-5000

Dr. Borroso
Cooper City, Fl
954-432-1500

11011 Sheridan St #303 Hollywood, Fl 33026

Signature [redacted]

Title IMC II

Telephone # [redacted]

DMA-5009 (08-08)

Dr. Skoe & Steinberg
North Shore Medical Center - emphasis assess
Miami, Fl
305-835-6000
1100 NW 95th St.
Miami, Fl 33150

0 % complete

DISABILITY DETERMINATION ASSESSMENT DISABILITY DETERMINATION ASSESSMENT CONTACT INFORMATION

Disability Determination Assessment Contact Information

Print

Help

Please complete the assessment questionnaire

Application Date * 1/30/2017

Special Review Assessment * Yes

Date Consent Forms Mailed

Protected Medicaid Status for Non-SSI child --Please Select--

Help

Person Providing Information and Telephone # (if different from claimant)

Last Name

First Name

Apt/Suite

Street 1

Street 2

City

County --Please Select--

State --Please Select--

Zip

Phone Area Code

Phone Number

Email Address

Mental Impairment

Help

If a mental impairment is alleged,if there is evidence of drug or alchol abuse or if the person is homeless,in a shelter or in a halfway house,please give name,address and phone number of someone who can be contacted as a third party

Last Name

First Name

Apt/Suite

Street 1

Street 2

City

County --Please Select--

State --Please Select--

Zip

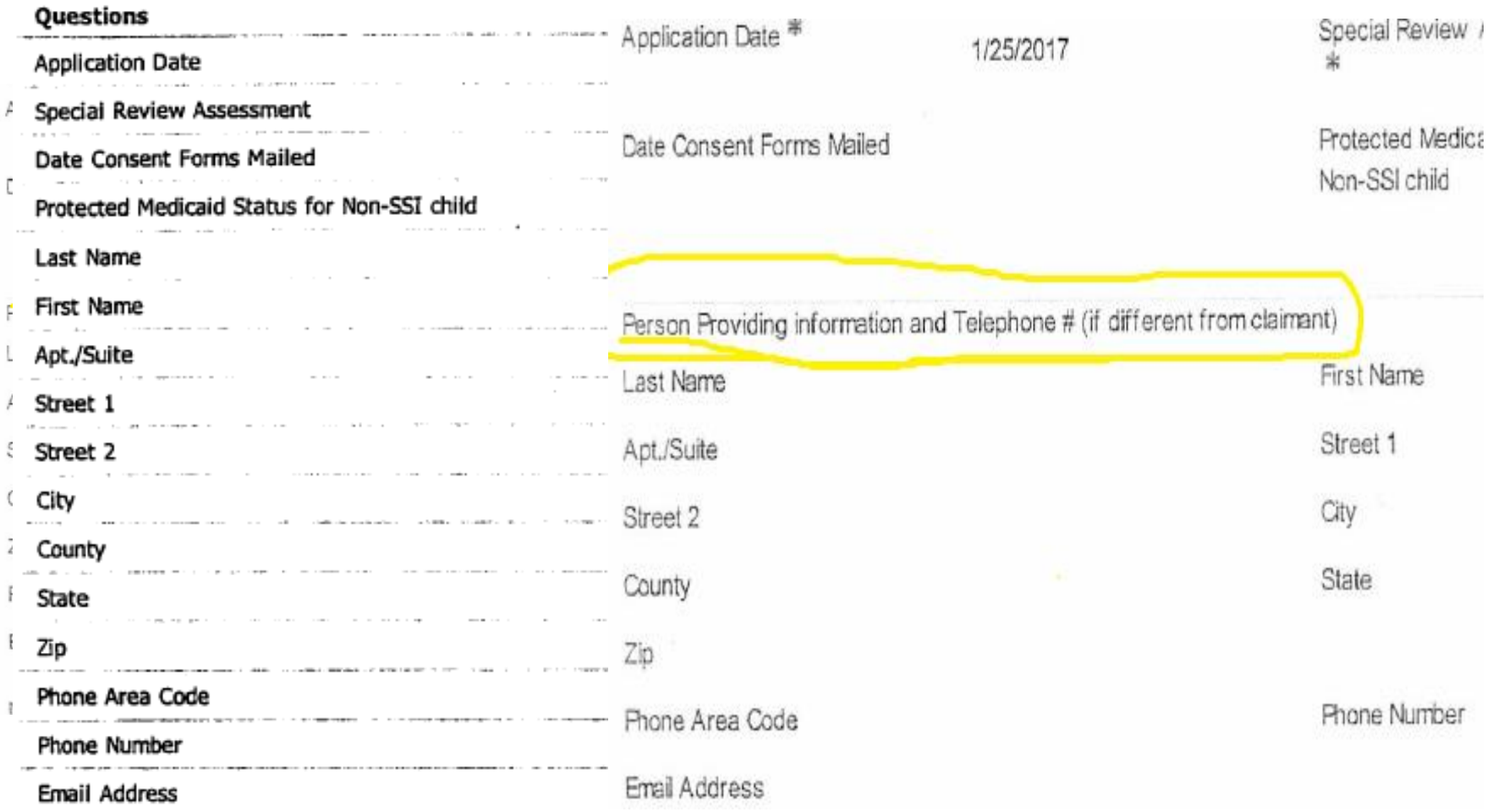
Phone Area Code

Phone Number

Email Address

Incomplete Assessment as indicated by "Please select" on drop down box

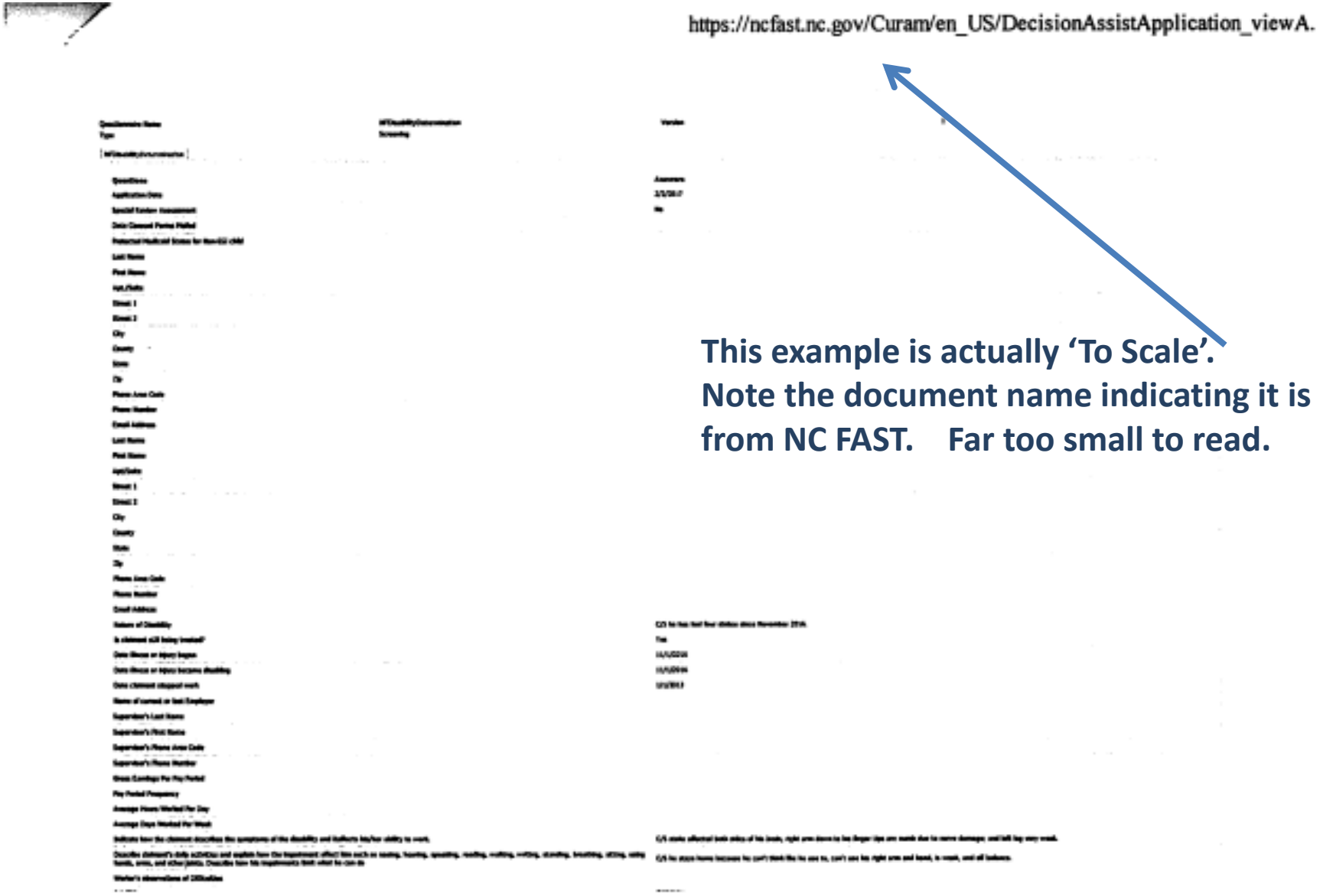
Assessment- Left side without header vs right side with header information



Questions
Application Date
Special Review Assessment
Date Consent Forms Mailed
Protected Medicaid Status for Non-SSI child
Last Name
First Name
Apt./Suite
Street 1
Street 2
City
County
State
Zip
Phone Area Code
Phone Number
Email Address

Application Date *	1/25/2017	Special Review *
Date Consent Forms Mailed		Protected Medica Non-SSI child
Person Providing information and Telephone # (if different from claimant)		
Last Name		First Name
Apt./Suite		Street 1
Street 2		City
County		State
Zip		
Phone Area Code		Phone Number
Email Address		

https://ncfast.nc.gov/Curam/en_US/DecisionAssistApplication_viewA.



This example is actually ‘To Scale’.
Note the document name indicating it is from NC FAST. Far too small to read.

DSS Case Worker did not get all the medical information.

List all Medical Sources (physicians, hospitals, emergency facilities, health departments, therapists, nursing homes, clinics, mental health centers,) including names and dates seen in the last twelve months. Give hospital or clinic number, which is on hospital or clinic card or hospital bills. (Twelve months prior to and including application month, plus any future medical appointments)

Medical Source Name, Address, Ph. #	Condition Treated EKG, X-rays	Dates Seen at Dr.'s office, clinic, hospital
Duke Raleigh		08/2016
Heart Doctor(Unsure of name)		
Client will provide this information		
at a later date. (919)		
Please Call Client 225-8603		

The 5028-Release of Information

- HIPPA compliant release forms are required to obtain medical evidence of record from all medical providers.

- The updated version dated September 2015 or later must be used.

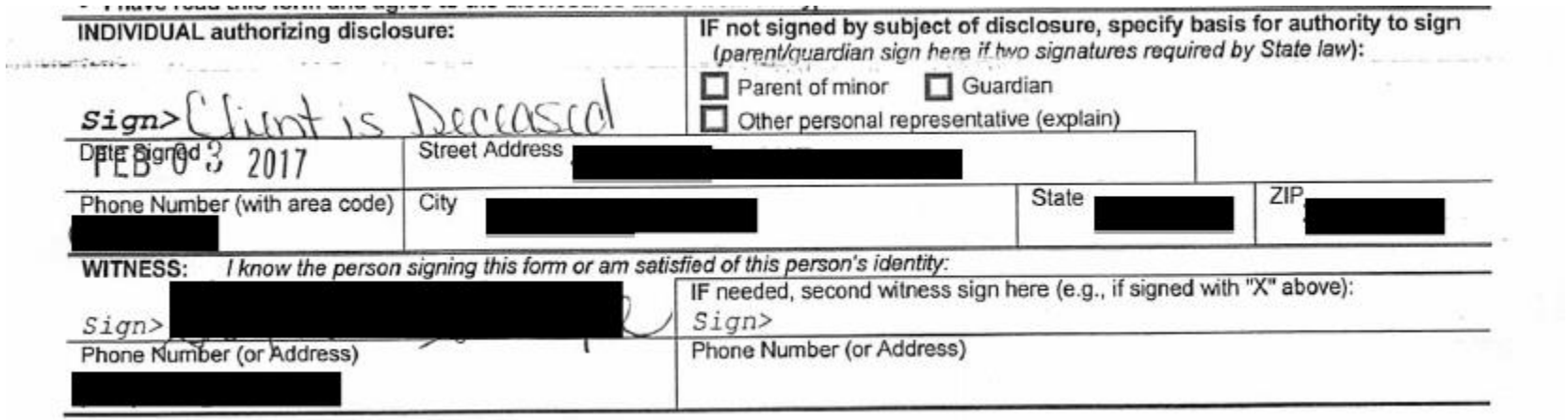
5028 Requirements

- Single duplexed form (9/15 or later version)
- Complete name, SSN, and date of birth
- Original signature of claimant and witness (no electronic signatures accepted)
- Must be dated
- Black and blue ink accepted by the medical community
- One original 5028 required for each source listed plus one extra
- No white out or lined corrections

5028 Requirements

- If there is a Power of Attorney or other acceptable authorized representative designated, include a copy of the document along with the signed and dated 5028.
- Appendix C, Authorized Representative Form, is not an acceptable form to obtain medical evidence of record from the medical community.

Example 5028- inadequate signature



INDIVIDUAL authorizing disclosure:	IF not signed by subject of disclosure, specify basis for authority to sign (parent/guardian sign here if two signatures required by State law):
Sign> Client is Deceased	☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)
Date Signed FEB 03 2017	Street Address [redacted]
Phone Number (with area code) [redacted]	City [redacted] State [redacted] ZIP [redacted]
WITNESS: *I know the person signing this form or am satisfied of this person's identity:*	
Sign> [redacted]	IF needed, second witness sign here (e.g., if signed with "X" above): Sign>
Phone Number (or Address) [redacted]	Phone Number (or Address)

REMINDERS

1. Include ***complete*** prior DDS decisions
2. Include all available medical records
3. Include Medicaid Appeal decisions (especially if this reversed the previous Medicaid DDS decision)

INMATE CASES

DMA Administrative Letter 09-08

Provided policy and instructions for inmate applications submitted to cover medical treatment outside the Department Public Safety (DPS) system

Disability Application for Inmate Case

- Complete 4037 (use address of DPS)
- Complete 5009/Assessment (Social History)
- Signed and dated DMA 5028 (Authorization for Disclose information for each medical source(s))
- Twelve months of medical records, both physical and mental, from DPS and the outside medical sources

Disability Application for Inmate Case

- DPS will forward the application, authorizations, and medical records to the inmate's last county of residence for processing.
- DSS submits the entire application packet and medical records to DDS for adjudication

DECEASED CLAIMANTS

- Complete 4037 (annotated as deceased)
- Complete 5009/Assessment (Social History)
- Signed and dated DMA 5028 by an authorized person established by a power of attorney (POA), if applicable.
- Death certificate (final version preferred)
- Medical records pertaining to reason of death and to establish onset of the medical condition, if available

APPLICATIONS FROM HOSPITALS

- Complete 4037
- Complete 5009/Assessment (Include complete social history with all medical sources seen in the past 12 months)
- Signed and dated DMA 5028 for each medical source listed plus one extra. Include POA when required
- NOTE: Hospital medical records submitted could possibly expedite the process

Reasons for cases to be returned to DSS

1. 5028 – not signed, not dated, not witnessed, not duplexed, no POA included
2. 5009/Assessment – not complete, illegible, source information incomplete, no treatment dates
3. Incorrect SSN or identifying information on 5028s
4. Information “whited out” or crossed out on 5028
5. 4037 or 5028 or 5009/Assessment not submitted with the packet
6. Wrong version of the 5028. Must submit version 9/15 or later